Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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119 King Street West 11th Floor
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 20, 2019	2018_558123_0016	031839-18, 032045-18	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

The Village of Tansley Woods
4100 Upper Middle Road BURLINGTON ON L7M 4W8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 7, 11 and 12, 2018.

The following complaint inspection was completed during this inspection: #032045 -18 related to medication incident/adverse drug reaction.
The following critical incident inspection was completed during this inspection: #031839-18 related to medication incident/adverse drug reaction.

During the course of the inspection, the inspector(s) spoke with residents, family members, registered nursing staff, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

During the course of this inspection, the inspector: reviewed the home's medication management program; reviewed the home's incident investigation record and reviewed residents' records.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in

the home unless the drug was prescribed for the resident.

A critical incident (CI) report submitted to the MOHLTC by the home on an identified date in December 2018, was reviewed and it was noted that on that date resident #001 was involved in a medication incident/adverse drug reaction. The resident was assessed by staff, noted to have an acute change in their health status and was transferred to the hospital. While at the hospital, it was determined the resident had an identified narcotic medication in their system. The resident was not prescribed that medication at the home. The home was informed of the hospital test results and initiated an investigation. The resident's substitute decision-maker (SDM), the resident's attending physician, the home's Medical Director, the Director of Care (DOC), the home's pharmacy service provider and the police were notified of the incident. The resident returned to the home.

An anonymous complaint related to the incident was also received by the MOHLTC on an identified date in December 2018. The complainant reported information as above.

The home's records including; the investigation record and the medication administration policy and procedure were reviewed. The documents included information as noted above. It was also noted that on an identified date in December 2018, the resident's attending physician informed the DOC that further testing of resident #001 was completed and the results were positive for four identified medications including the identified narcotic medication. These medications were prescribed for resident #002 and were not prescribed for resident #001.

The health records of residents #001 and #002 including the November 2018, Medication Administration Records (MARs), care plans and progress notes were reviewed. On an identified evening in November 2018, both residents were noted to have received medications and resident #002 was noted to have been administered the medications noted above. Resident #001's diagnostic test results dated December 2018, indicated positive results for resident #002's medications as noted above.

The DOC confirmed the accuracy of the information as noted in the residents' health records and the home's investigation records including, the wrong medications were administered to the residents. They also reported resident #001 had no lasting ill- effects as a result of the incident. They returned to the home and back to their pre-incident level of health.

Registered staff #102 was interviewed and reported information related to the medication

incident involving residents #001 and #002 as noted in the residents' health records and the home's investigative records. Specifically, they confirmed they inadvertently administered resident #002's medications to resident #001 and resident #001's medications to resident #002.
On an identified date in December 2018, medications were administered to residents #001 and #002 which were not prescribed for them. [s. 131. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy of system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

According to Ontario Regulation 79/10, s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home's pharmacy service provider's, Medication Pass Policy, #MEDI-CL-003, dated October 1, 2018, was reviewed and included: "The Eight Rights of Medication Administration" must be observed when administering medications to reduce medication incidents."; "Avoid conversation and attempt to minimize distractions when preparing medications." and "Verify the resident's identity using two identifiers."

Registered staff #102 was interviewed and reported that on an identified date in December 2018, during the identified medication administration passes for residents #001 and #002: they poured the residents' medications; left the medication cart inside the medication room; administered the residents' medications; returned to the medication room and documented the administrations of the medications. They acknowledged they did not take the medication cart with them to the residents' rooms and had prepared the medications in the medication room. They reported that they did not verify the identity of residents #001 and #002 while administering the medications as they felt they knew the residents. They also reported being interrupted during medication administration.

The DOC was interviewed and reported the home's expectations were for staff to follow the medication administration policy and procedure as noted above including: the staff were to verify the identity of each resident; take the medication cart with them and prepare the medications for one resident at time. They confirmed the registered staff did not follow the home's medication administration policy and procedure when administering the medications to residents #001 and #002.

On an identified date in December 2018, the home's medication administration policy and procedure was not complied with in relation to the above medication incident. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy of system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker (SDM), if any, and any other persons designated by the resident or SDM were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Critical incident report submitted to the MOHLTC on an identified date in December 2018, was reviewed. An anonymous complaint (032045-18) was made to the MOHLTC related to the above incident.

The health record of resident #001 including the care plan, progress notes and Advanced Care Directive (ACD) was reviewed. Progress note documentation indicated that on an identified date in December 2018, a Personal Support Worker (PSW) noticed that the resident did not respond to an environmental stimuli as they usually did. The registered staff was notified and assessed the resident. It was noted health status had deteriorated. The resident's vital signs were also assessed and identified results were outside the

normal range. It was suspected the resident may have had an identified medical condition. The physician was notified and a discussion was held. It was determined the resident was to receive an identified level of care as per their ACD and the registered staff were to contact the resident's SDM at an identified time. The staff would continue to monitor the resident and inform the day-shift registered staff.

Progress note documentation of an identified date and time in December 2018, indicated the resident's SDM was contacted and informed of the change in the resident's health status. The resident's ACD of an identified level of care was discussed. The SDM requested the resident be transferred to an acute care hospital for further assessment. The physician was notified and the resident was transferred to hospital.

The ACD dated September 2018 and signed by the resident's SDM indicated the resident was to receive an identified level of care.

The home's investigative record was reviewed and it was noted that on an identified date in December 2018, the Assistant Director of Care (ADOC) discussed the incident with registered staff #103. The discussion included: On an identified date and time in December 2018, resident #001 had a change in their health status and was assessed by registered staff #103. The physician was contacted and provided an update on the resident's status. The physician indicated the resident was to receive an identified level of care and directed registered staff to follow the instructions listed in the ACD. Registered staff #103 spoke to registered staff #104 who informed them that SDMs can override the ACD anytime there is an acute change in the resident's health status. The resident's SDM was contacted one hour and fifty minutes after the incident occurred.

The DOC was interviewed and confirmed the accuracy of the information in the resident's health record and the home's record. They also confirmed the home failed to ensure that the resident #001's SDM was given an opportunity to participate fully in the development and implementation resident #001's plan of care when the resident's health status changed and it was suspected they experienced an identified health event on an identified date and time in December 2018.

The SDM of resident #001 was not provided an opportunity to participate fully in the development and implementation of the resident's plan of care as noted above. [s. 6. (5)]

Issued on this 21st day of February, 2019

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELODY GRAY (123)
Inspection No. / No de l'inspection :	2018_558123_0016
Log No. / No de registre :	031839-18, 032045-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 20, 2019
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Tansley Woods 4100 Upper Middle Road, BURLINGTON, ON, L7M-4W8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ripu Phull

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Schlegel Villages Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee must be compliant with Ontario Regulation 79/10, s. 131 (1).
Specifically, the licensee must:
1. Ensure that no drug is used by or administered to residents #001, #002 and any other resident unless the drug has been prescribed for the resident.
2. Develop, communicate and implement a monthly auditing process to ensure that residents receive only medications prescribed for them and initiate corrective action when discrepancies are identified. The results of the audits and corrective actions are to be documented.

Grounds / Motifs :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug was prescribed for the resident.

A critical incident (CI) report submitted to the MOHLTC by the home on an identified date in December 2018, was reviewed and it was noted that on that date resident #001 was involved in a medication incident/adverse drug reaction. The resident was assessed by staff, noted to have an acute change in their health status and was transferred to the hospital. While at the hospital, it was determined the resident had an identified narcotic medication in their system. The resident was not prescribed that medication at the home. The home was informed of the hospital test results and initiated an investigation. The resident's substitute decision-maker (SDM), the resident's attending physician, the home's Medical Director, the Director of Care (DOC), the home's pharmacy service provider and the police were notified of the incident. The resident returned to the home.

An anonymous complaint related to the incident was also received by the

MOHLTC on an identified date in December 2018. The complainant reported information as above.

The home's records including; the investigation record and the medication administration policy and procedure were reviewed. The documents included information as noted above. It was also noted that on an identified date in December 2018, the resident's attending physician informed the DOC that further testing of resident #001 was completed and the results were positive for four identified medications including the identified narcotic medication. These medications were prescribed for resident #002 and were not prescribed for resident #001.

The health records of residents #001 and #002 including the November 2018, Medication Administration Records (MARs), care plans and progress notes were reviewed. On an identified evening in November 2018, both residents were noted to have received medications and resident #002 was noted to have been administered the medications noted above. Resident #001's diagnostic test results dated December 2018, indicated positive results for resident #002's medications as noted above.

The DOC confirmed the accuracy of the information as noted in the residents' health records and the home's investigation records including, the wrong medications were administered to the residents. They also reported resident #001 had no lasting ill- effects as a result of the incident. They returned to the home and back to their pre-incident level of health.

Registered staff #102 was interviewed and reported information related to the medication incident involving residents #001 and #002 as noted in the residents' health records and the home's investigative records. Specifically, they confirmed they inadvertently administered resident #002's medications to resident #001 and resident #001's medications to resident #002.
On an identified date in December 2018, medications were administered to residents #001 and #002 which were not prescribed for them.

The severity of this issue was determined to be level three as there was actual harm or risk to the resident. The scope of the issue was determined to be level two as it was found to be a pattern, involving two of the three residents. The

home's compliance history was determined to be four because despite MOHLTC action (VPC, Order) non-compliance continues with the original area of noncompliance including: VPC issued May 16, 2018 (2018_546585_003). (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 15, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 20th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MELODY GRAY

Service Area Office /
Bureau régional de services : Hamilton Service Area Office